

**Testimony on Substitute for House Bill 5345
Public Employee Health Care Reform Committee**

Speaker Andy Dillon

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The purpose of this presentation is to . . .

- Present to the Committee the Substitute for House Bill 5345
- Define the areas of the original bill that remain the same
- Explain the changes
- Answer questions

The basic tenets of the original legislation remain unchanged

- Covers all public employees and retirees who are offered health benefits
 - “From the local school bus driver to the Governor”
- 13-member Board continues to define health benefit plan designs
 - Engages both public employees and public employers





The basic tenets of the original legislation remain unchanged

- Preserves collective bargaining over the selection of plans, premium share and eligibility
 - Adds collective bargaining over participation in the program ★
- Offers an array of benefit plan designs to meet the diverse needs of public employees
- Provides a pro-worker, pro-taxpayer solution

The basic tenets of the original legislation remain unchanged

- Ensures access to high-quality health care while maximizing opportunities to contain costs
- Streamlines processes to maximize administrative efficiencies and minimize administrative costs
- Mandates certain plan design features, such as wellness, consumer engagement, evidence-based care and value-based insurance design

Importantly, the impetus remains the same - eliminate unnecessary cost and leverage scale

- Keep teachers in the classrooms 
- Keep police on the streets 
- Sustain other important public services 
- Preserve high-quality benefit programs in the public-sector 

The substitute modifies the original bill by

- Responding to areas of concern voiced during the committee hearings ★
- Incorporating many of the recommendations made by the work groups ★
- Continuing to provide the opportunity for savings ranging from \$700 million to \$900 million

The substitute incorporates a number of major changes

- Establishes a process to verify the savings prior to program implementation ★
 - Sets savings threshold at 2% of current cost
 - Provides a time line with due dates
 - Collects demographic, cost, and claims data
- Makes available additional avenues for opting out of the program ★
 - Unions and management bargain over participation

The substitute incorporates a number of major changes

- Establishes the MI Prescription Drug Plan ★
- Clarifies the roles and responsibilities of the Board and Office of State Employer (OSE) ★
- Allows the Board to create subcommittees to broaden participation in the process ★
- Creates the position of Chief Executive Officer under the OSE

The substitute incorporates a number of major changes

- Sets criteria to be used by the Board and OSE in the RFP process ★
- More clearly defines terms used in the legislation ★
- Provides greater clarity on mandatory program features and audit requirements ★

The substitute incorporates a number of major changes

- Establishes a maximum amount to be paid for health benefits by public employers that opt out of the program
- Allows variances in premiums based on geographical areas ★
- Limits the amount that can be charged to cover the costs to implement and administer the program ★

The substitute bill is organized into seven articles

Article 1 – General Provisions

Article 2 – MI Health Benefits Board

Article 3 – Office of the State Employer

Article 4 – Health Benefit Plans

Article 5 – MI Prescription Drug Plan

Article 6 – Data Collection

Article 7 – Health Benefit Plans Implementation

There are two phases along the implementation continuum

Phase 1 – Program Validation

Phase 2– Program Implementation

A 13-member Board will represent the interests of both employees and employers

Employee/Retiree Reps (5)

All appointed by Governor

- 4 Labor/Employee Reps
 - State
 - Municipal
 - Public Education
 - Public Safety
- 1 Rep for Public Retirees

Employer Reps (5)

+ Serving by virtue of position
Appointed by Governor

- 1 - State Employer +
- 1 - State Budget Director +
- 3 - Public Employer Reps
 - County #
 - Municipal #
 - Public Education #

Independent Subject Matter Experts (3)

1 Appointed by Governor
1 Recommended by Speaker of the House
1 Recommended by Senate Majority Leader

- Expected expertise includes
 - Employee benefit plan design
 - Value-based insurance design
 - Actuarial science

- Board appointed primarily by the Governor, with recommendations from interested groups and constituents
- All board members have an equal voice in the process
- All board members accountable to legislative parameters



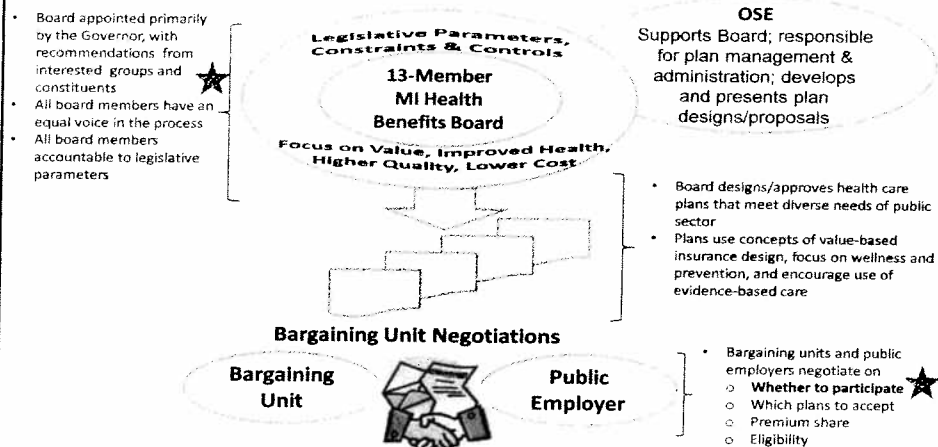
Legislative Parameters,
Constraints & Controls

13-Member MI Health Benefits Board

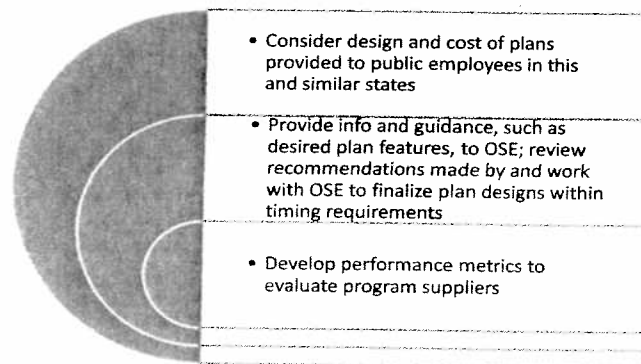
Focus on Value, Improved Health,
Higher Quality, Lower Cost

- Individuals who work for a program supplier shall not hold a position on the Board
- Individuals serve rotating 4-year terms


The Board will provide program oversight and governance in both phases




The Board shall . .



The Board's roles and responsibilities shall also include . . .

- 
- Issue directions to OSE as to changes to be researched, developed, included, and resubmitted
 - Assess the financial stability of the program
 - Approve the annual operating budget
 - Monitor fund investments

The Board's roles and responsibilities shall also include . . .

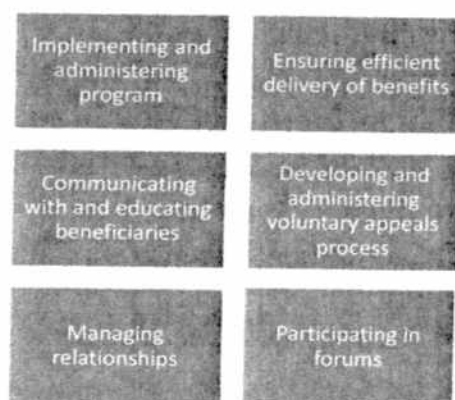
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- Determine if the purchase of reinsurance is in state's best interests
 - Approve and adopt plan documents
 - Conduct periodic beneficiary satisfaction surveys
 - Review results of voluntary appeals

The Board's roles and responsibilities shall also include . . .

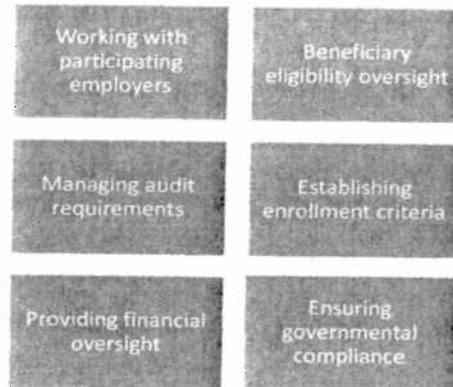


- Approve all governmental filings
- Approve Executive Director expense reports
- Deliver annual status report to legislature
- Develop methods to extend program to private sector

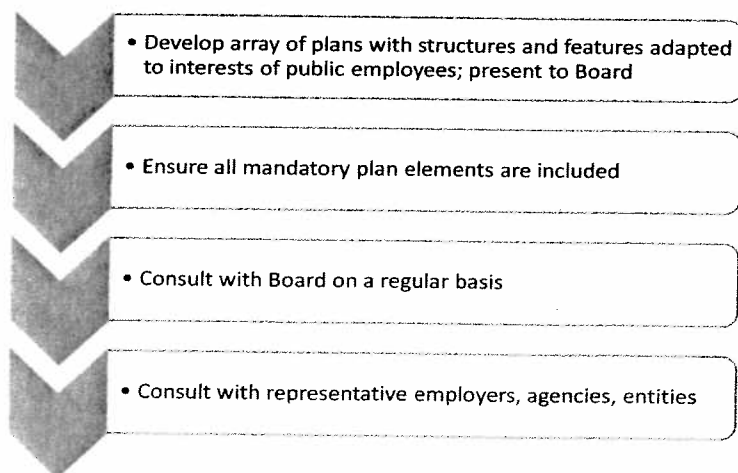
The OSE has the following general powers, duties and responsibilities . . .




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The OSE's duties related to plan design include. . .



The OSE's duties related to plan design include. . .

- 
- Review available benefit plan designs and costs for other plans/programs
 - Periodically review and update plan designs
 - Manage the RFP process, including evaluation
 - Recommend program suppliers to Board

The OSE's duties related to plan design include. . .

- 
- Work with actuaries to calculate Illustrative Average Annual Premium
 - Negotiate contracts
 - Communicate with public employers and manage enrollment
 - Prepare annual report for legislature

Program supplier expectations include . . .

- Financial stability

- Accreditation by national agencies

- High-quality, patient-centered care

- Proven effectiveness as strategic partner

Program supplier expectations include . . .

- Competitive pricing

- Simplified admin practices

- Efficient, cost-effective networks

- Promotion of evidence-based care and compliance with best practices

Program supplier expectations include . . .

- Willing to meet desired standards for delivery of program

- Health, wellness, prevention and care management programs, including incentives and incorporation of value-based

- Outstanding customer service

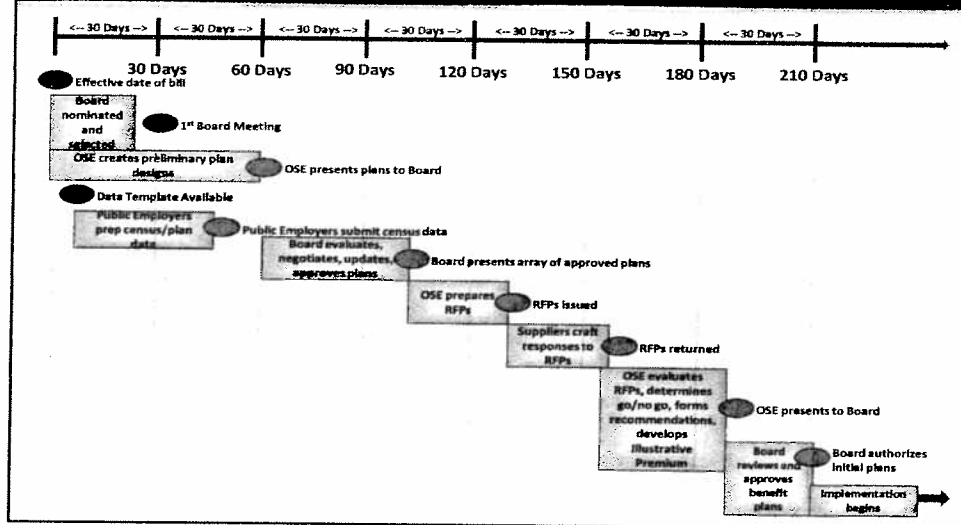
- Seamless coordination with other program suppliers

A comprehensive list of activities will be undertaken during program validation

PHASE ONE – PROGRAM VALIDATION

- 13-Member Board appointed (20 days); holds first meeting (10 days); 30 days from effective date
- Board provides recommendations and input to OSE within 15 days from their first meeting = 45 days from effective date
- OSE develops template to collect data from public employers (5 days); public employers respond (45 days); 50 days from effective date
- OSE develops array of health benefit plans; 60 days from effective date
 - Hires "interim executive director" and outside consultant to take lead in developing innovative, cost-effective plan designs
 - Consults with governor's office for info on health plans developed or proposed by the executive branch
 - Consults with, collects and uses plan design info from representative group of public employers
 - Reviews and considers plan designs and cost data on private employee benefit plans in Michigan
 - Reviews available plan design and cost data on public employee benefit plans in similar states
 - Confers with the board before and during the design process
 - Presents initial array of plans to board, including cost share and projected premiums
- Board reviews and approves OSE recommendations; may ask OSE to modify – 45 days; 105 days from effective date
 - Reviews and considers current public employee benefit levels in this state
 - Reviews and considers plan design and cost data on private employee benefit plans in Michigan
 - Reviews and considers available data on public employee benefit plans in similar states
 - Provides info and guidance to the OSE
 - Considers array of plans submitted by OSE based on
 - Quality, efficiency, effectiveness in improving health of public employees
 - Financial stability and cost
 - Submits recommended array of health benefit plans or OSE recommended plans are used if board does not approve within 45 days
- OSE working with a consultant develops and issues RFPs – 30 days; 135 days from effective date
- Suppliers return RFPs – 30 days; 165 days from effective date
- OSE evaluates RFPs – 30 days; 195 days from effective date
 - Contracts with actuary to assess Michigan public employer data, reviews RFP responses, assess savings, prepare report for board
 - If actuarial analysis yields 2% of more savings can be obtained, program is a "go" and suppliers are selected
 - Develops Illustrative Average Annual Premiums, by coverage type, with assistance from actuary
 - Illustrative annual premium = lowest cost plan allowing for geographic pricing based on actuarial recommendation and excluding High Deductible Plans with HSA features
 - 3 types of illustrative premiums will be calculated: 1= all health benefits including Rx; 2= health benefits excluding Rx; 3= Rx only
- Board approves recommendations and authorizes plan implementation – 15 days; 210 days from effective date
- Program implementation begins

With the process to validate the savings taking 210 days



The program is a "GO" if . . .

Savings of 2% or more is validated in Phase 1

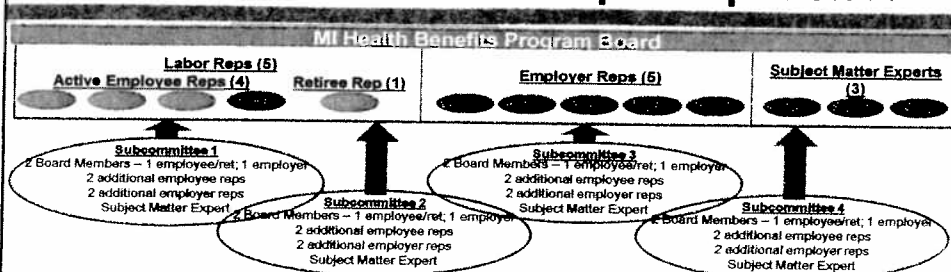
- Approximately \$100 million based on an estimated \$5 billion in current cost
- Represents a level of savings where it is difficult to say "no"

The Board and OSE have ongoing responsibilities if program is implemented

PHASE TWO – PROGRAM IMPLEMENTATION

- 13-Member Board continues
- Board may elect to appoint subcommittees
- OSE appoints "executive director" (no longer interim position) to manage and administer the program
- Executive Director working with outside consultants and actuaries reviews program on a regular basis, at least annually, and makes recommendations for program modifications to keep the program focused on improving the health of participants while containing costs
- Board provides input and direction to OSE and reviews and approves OSE recommendations; may ask OSE to modify
- All program modifications must be presented to the board no later than 10 months before the beginning of each succeeding plan year, and approved by the board within 60 days or the recommendations of the OSE stand
- New Illustrative Average Annual Premiums by coverage type will be developed each year based on program offerings and expected program participation levels
- Prepare and present an annual report to the legislature

After implementation, the Board may create subcommittees to broaden participation ★



Notes

- Upon successful launch of the MI Health Benefits Program, the Board may authorize the creation of subcommittees to assist and support the Board going forward – each subcommittee must focus on an area that is distinct & different from any other subcommittee
- Subcommittees will be responsible for evaluating initiatives to keep the Program current, efficient, cost-effective and relevant and will recommend new plan designs, ongoing program improvements, etc. to the Board
- Subcommittees may be somewhat permanent (such as plan design or Rx) or may be temporary to evaluate a new concept
- Subcommittees meet at least once per quarter
- Subcommittees make recommendations to the Board – those recommendations require a Board vote to be enacted
- Two Board members serve as co-chairs of each subcommittee, one represents employees/retirees and one represents employers
- Board Subject Matter Experts will not chair a subcommittee but will participate as resources to the subcommittees
- There will be no more than seven total members of a subcommittee, with equal distribution between employee and employer reps; participating SMEs will vote on subcommittee recommendations when/if a tie-breaker is required
- Board members may nominate individuals to serve on subcommittees; such nominations must be confirmed the members serving on the Board, subcommittee members may not work for may not have vested interest in any existing or potential program supplier

The plans offered through the program must include the following elements:

Features that maximize cost containment while ensuring access to quality health care

Streamlined administrative processes that maximize efficiencies and minimize costs

Wellness or healthy lifestyle programs and prevention incentives for beneficiaries

Appropriate networks
Evidence-based care and best practices
Value-based insurance design

Clinical advocates offered as a confidential resource at the beneficiary's discretion, if such a resource is proven cost effective

The plans offered through the program must include the following elements:

Coordination of care across the various benefit providers

Coordination of benefits with any other available policy, certificate, contract or plan

Incentives for beneficiaries to encourage enrollment in high-deductible health plans

Disease and chronic care management

Compliance with HIPAA

A consolidated prescription drug plan is established

- Known as the MI Prescription Drug Plan
- To be structured and administered in a way that maximizes savings, efficiencies, affordability, benefits, coverage, patient safety, and health outcomes
- Available either separate from or as part of other benefits available through the program

A consolidated prescription drug plan is established

- Will include options adapted to the needs of employees and employers
- Creates the MI Prescription Drug Plan Committee to develop prescription drug formulary and to recommend drug management protocols
 - Formulary must be first based on quality and efficacy and then cost
 - Committee members may not have a conflict of interest

The MI Prescription Drug Plan Committee is comprised of 11 members

- Executive director of program or his/her designee
- Three prescribers with patients in the program
- Two prescribers with research doctorates and expertise in evidence-based prescribing or pharmacoeconomics
- Three pharmacists
- Two pharmacists with doctorates in pharmacy and expertise in evidence-based prescribing or pharmacoeconomics

Public employers must provide demographic, cost and claims data

- Establishes a base line for current cost
- Provides data necessary to complete the RFP
- All data to be de-identified
- Proprietary data to be protected
- Not subject to FOIA

There are now more avenues to opt-out of the program ★

- A public employer may opt out if that employer can provide independently or through a pooling arrangement, comparable (or better) benefits at lower cost
 - Does not have to provide documentation unless requested by Board
- A public employer at its sole discretion may elect to opt out for its non-represented employees

There are now more avenues to opt-out of the program ★

- A public employer and each of the individual units of the employer's exclusively represented employees may agree to opt out of the program
 - The individual units will negotiate participation in the program through their collective bargaining process

There are now more avenues to opt-out of the program ★

- It is possible to opt-out of health benefits while staying in the prescription drug plan, or vice versa
- When opting out of the program, the maximum amount that a public employer may pay for health benefits is the Illustrative Average Annual Premium

The Illustrative Average Annual Premium

- Will be calculated for three types of benefits
 - Comprehensive, which is the total of health benefits and prescription drug coverage
 - Prescription drug benefits
 - Health benefits other than prescription drugs
- Will further be available by type of coverage
 - Single
 - 2-party
 - Employee + Children
 - Full Family

The Illustrative Average Annual Premium

- Represents the lowest cost plan offered through the program
 - Excluding any high deductible health plan with an HSA component
 - May be determined by separate geographical areas if actuarially valid
- Where total costs and total enrollment initially are based on 50% participation in the program

Charges to implement and administer the program are limited to . . . ★

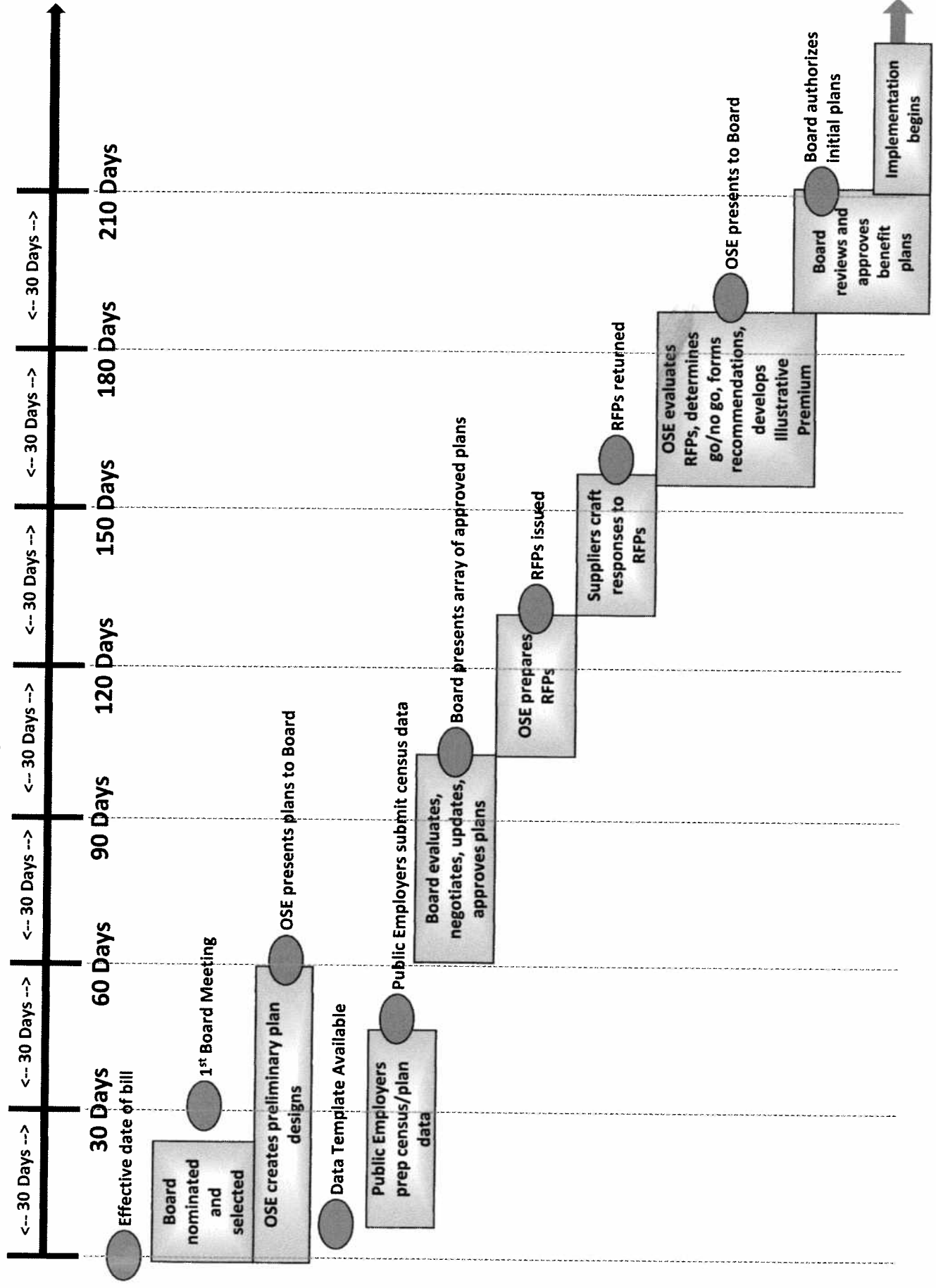
- One percent of premiums when 50% or more of public employees participate
- Two percent of premiums when less than 50% of public employees participate

In summary,

**The MI Health Benefits Program good
for Michigan, its workers and its
taxpayers!**



MI Health Benefits Program Validation and Implementation Time Line



**THE MI HEALTH BENEFITS PROGRAM
SPEAKER DILLON'S PRESCRIPTION FOR PUBLIC-SECTOR HEALTH CARE REFORM
SYNOPSIS OF THE SUBSTITUTE LEGISLATION**

BACKGROUND

- Speaker Dillon first proposed the MI Health Benefits Program in July 2009 to generate annual savings of \$700 million to \$900 million by consolidating the administration and delivery of health benefit programs across Michigan's public sector
- Legislation (House Bill 5345) was introduced in the Michigan House of Representatives in September 2009
- Thirteen-member bipartisan Public Employer Health Benefits Redesign Committee chaired by Rep. Pam Byrnes was appointed in September 2009
 - Regular committee meetings were held through December 2009 to allow constituents and interested parties the opportunity to share their opinions and provide input
- Five Work Groups were in December 2009 to evaluate issues and define opportunities specifically associated with Administration; Board Composition; Plan Design Elements and Opt-Out Process; Prescription Drugs; and Retirees
- Work Groups presented recommendations and findings in February 2010 for consideration in substitute legislation

HIGHLIGHTS OF THE SUBSTITUTE LEGISLATION

- Responds to areas of concern voiced during the committee hearings
- Incorporates many of the recommendations made by the work groups
- Continues to provide the opportunity for savings ranging from \$700 million to \$900 million annually across Michigan's public sector
- Reinforces the state's commitment to provide fair and competitive health benefits to public employees and retirees (i.e., does not strip benefits from public employees and retirees)
- Provides employer-based health benefit plans; this is not a government-run program

WHY THIS LEGISLATION IS NEEDED

- Creates systemic change to address Michigan's perennial budget problems
 - One of many wide-ranging reforms needed to help make Michigan and its communities financially viable once again
- Eliminates the cost of redundancies and non-value added services to help the state, school districts, municipalities, and other governmental units retain employees AND continue to offer high-quality health benefit programs
 - Keeps teachers in the classroom
 - Keeps police on the streets
 - Sustains other important public services
 - Takes care of the needs of public employees by preserving high-quality benefit programs
- Honors public employers' fiduciary responsibility to wisely spend taxpayer dollars

5/20/2010

THE MI HEALTH BENEFITS PROGRAM – SYNOPSIS OF THE SUBSTITUTE LEGISLATION

MAJOR CHANGES

- Establishes a process to verify the savings prior to program implementation
 - Sets savings threshold at 2%--or about \$100 million of the estimated \$5 billion currently spent--over current costs as the minimum needed to make the program viable
 - Provides a time line and due dates to complete the verification process
 - Collects demographic, cost and claims (non identified) data from public employers
- Makes available additional avenues for opting out of the program
 - Allows unions and management to bargain over participation in the program
- Establishes the MI Prescription Drug Plan to leverage savings opportunities associated with prescription drugs
 - Creates the MI Prescription Drug Plan Committee to develop a prescription drug formulary based on quality and efficacy followed by cost, and to recommend prescription drug management protocols
- Clarifies the roles and responsibilities of the MI Health Benefits Board and the Office of the State Employer (OSE)
- Creates the position of Chief Executive Officer of the program, under the OSE
- Allows the Board to create subcommittees to broaden participation in the process
- Sets criteria to be used by the Board and OSE during the RFP process
- More clearly defines terms used in the legislation
- Provides greater clarity on mandatory program features and audit requirements
- Establishes a maximum amount to be paid for health benefits by public employers that opt out of the program
- Limits the amount that can be charged to cover the costs to implement and administer the program
- Allows variances in premiums based on geographical areas as appropriate

WHAT STAYS THE SAME

- Covers all public employees and retirees who are offered health benefits, including elected officials – “From the local school bus driver to the Governor “
- 13-member Board continues to define health benefit plan designs
 - Engages public employees and public employers in the design of health benefit plans
- Preserves collective bargaining over selection of plans, premium share and eligibility
 - Adds collective bargaining over participation in the program
- Offers an array of benefit plan designs to meet the diverse needs of public employees
- Provides a pro-worker, pro-taxpayer solution
- Ensures access to high-quality health care while maximizing opportunities to contain costs
- Streamlines processes to maximize administrative efficiencies and minimize administrative costs
- Mandates the benefit plans offer a strong focus on wellness, and healthy lifestyle programs, disease management, prevention and consumer engagement incentives, compliance with evidence-based care and best medical practices, and value-based insurance design

5/20/2010